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**Medicaid Management Information Systems**  
***Maine Integrated Health Management Solution***  
***Health PAS Online: Professional Claim Submission***  
***and Claim Status User Guide***

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By accessing the Maine Health PAS Online Portal, all users agree to protect the privacy and security of the data contained within as required by law. Access to information on this site is only allowed for necessary business reasons, and is restricted to those persons with a valid user name and password.

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## 1. Introduction

Using the Maine Integrated Health Management Solution (MIHMS) Health PAS Online Portal (online portal), MaineCare providers can quickly and easily enter professional, institutional, and dental claims. This guide will walk the user through the process of entering a professional claim and modifying it as necessary.

***HINT:** If the user is not already a registered Trading Partner, click the link to the [Trading Partner User Guides](#) for more information*

## 2. Information Needed

Before beginning the claims submission process, it will be useful to have the following information, forms, and other documents on hand:

- Verify that the recipient is eligible on the date of service for the services rendered.
- Medicaid is always the payer of last resort. If the member has Medicare or third party insurance, bill them first before billing Medicaid.
- Gather complete member, provider and service information associated with the claim.

## 3. System Requirements

To successfully use all features of the online portal, ensure that computer systems meet the following minimum requirements:

- Reliable online connection
- Web browser - The latest version of Microsoft Internet Explorer is recommended. As new versions of Internet Explorer become available it is recommended that these versions are used.
- The latest version of Adobe Acrobat Reader

## 4. Form Entry: Claim Submission

To begin a claim submission, click the **Claim Submission** link located below the Form Entry heading on the portal links, as shown in [Figure 4-1](#) below. Now the Submit Claim – Find Member screen will display.



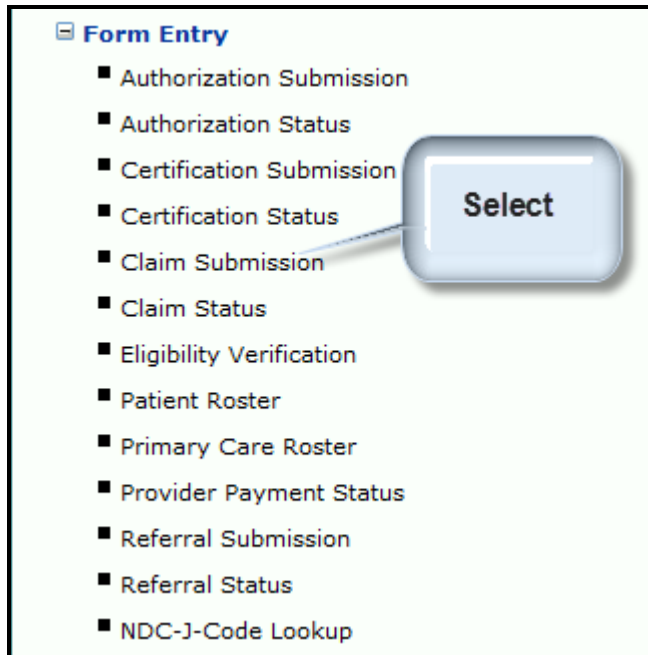


Figure 4-1: Claim Submission

The **Submit Claim** button is also available directly from the Eligibility Verification, Patient Roster, and Primary Care Roster screens.

The Submit Claim function uses a wizard to guide the user through the steps of the process. The wizard starts with Find Member, as shown in [Figure 4-2](#) below.

## 4.1 Step 1– Find Member

A screenshot of a web application's 'Find Member' search form. The form is titled 'Find Member' and is part of a wizard for submitting a claim. It includes a 'Select Billing Provider' dropdown menu, a 'Select a Claim Type' section with radio buttons for Professional, Dental, and Institutional, and a 'Find Member' button. Below these is a search instruction: 'To search for a member, enter search criteria in any two rows. For example enter the Name (last and first) and the Date of Birth.' The form contains several input fields: 'Member ID', 'Name (Last and First)', 'Date of Birth' (with a MM/DD/YYYY format hint), and 'Social Security Number' (with a ###-##-#### format hint). There are 'Submit' and 'Reset' buttons at the bottom right of the form.

Figure 4-2: Find Member

Use the instructions below to execute a member search associated with a claim submission. [Figure 4-2](#) above shows the Find Member Search Fields.

1. If there is more than one **Billing Provider** associated with the Trading Partner ID, click the drop-down menu to select the proper Billing Provider from the pre-determined list. [Figure 4-3](#) below, shows an example of a Billing Provider drop-down menu.

A screenshot of a web form element labeled "Select Billing Provider:" followed by a dropdown menu with a downward-pointing arrow.

**Figure 4-3: Select Billing Provider**

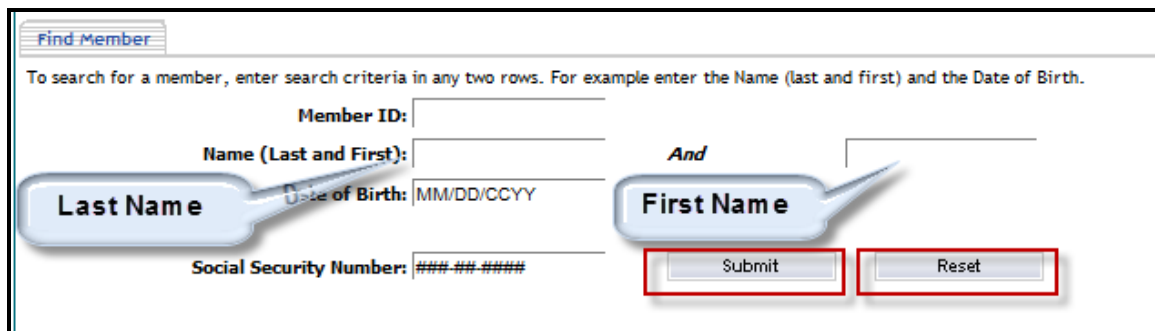
2. Select the proper claim type by clicking the radio button next to the “Professional” option.
3. Enter member search criteria. Two of the four available search criteria fields must be filled for a successful member search:
  - Member ID
  - Name (Last and First)
  - Date of Birth
  - Social Security Number

**Additional details on entering search criteria for the member search:**

- The **Last Name** and **First Name** count as one search criterion.
  - On the search screen, enter the Last Name in the first field and the First Name in the second field- see [Figure 4-2](#) above.
  - Names must match exactly for the first five letters of the last name and the first three letters of the first name.

***HINT:** If no match is found, try fewer criterions. For example: Jane Example-Member could be entered as Examp for the last name and Jan as the first name. Alternatively, do not use the name criteria, but MaineCare ID and Date of Birth.*

- The **Date of Birth** must be entered in the MM/DD/CCYY format.
  - For example, February 14, 2008 would be entered as “02/14/2008”.
- The **Social Security Number** should be entered without any dashes.


A screenshot of the "Find Member" search form. It includes a title bar "Find Member" and a instruction: "To search for a member, enter search criteria in any two rows. For example enter the Name (last and first) and the Date of Birth." The form has four input fields: "Member ID:", "Name (Last and First):", "Date of Birth: MM/DD/CCYY", and "Social Security Number: ### ## ####". There are callout boxes: "Last Name" points to the first part of the "Name (Last and First)" field, and "First Name" points to the second part. An "And" label is between the "Name" and "Date of Birth" fields. At the bottom right are "Submit" and "Reset" buttons, both highlighted with red rectangles.

**Figure 4-4: Member Search**

- Select the **Submit** button to perform a search.
  - a. To start the search over, select the **Reset** button to clear all the values entered in the Find Member search fields- see [Figure 4-4](#) above.
- The search results are returned under the Find Member Results tab, as depicted in [Figure 4-5](#) below. The results will include a list of all the members that meet the search criteria. It will display their Name, Gender, and Date of Birth.
  - a. **If the search returns multiple results**, select the correct member by clicking the checkbox in front of that member’s name as shown in [Figure 4-5](#) below. Click the **Continue** button.

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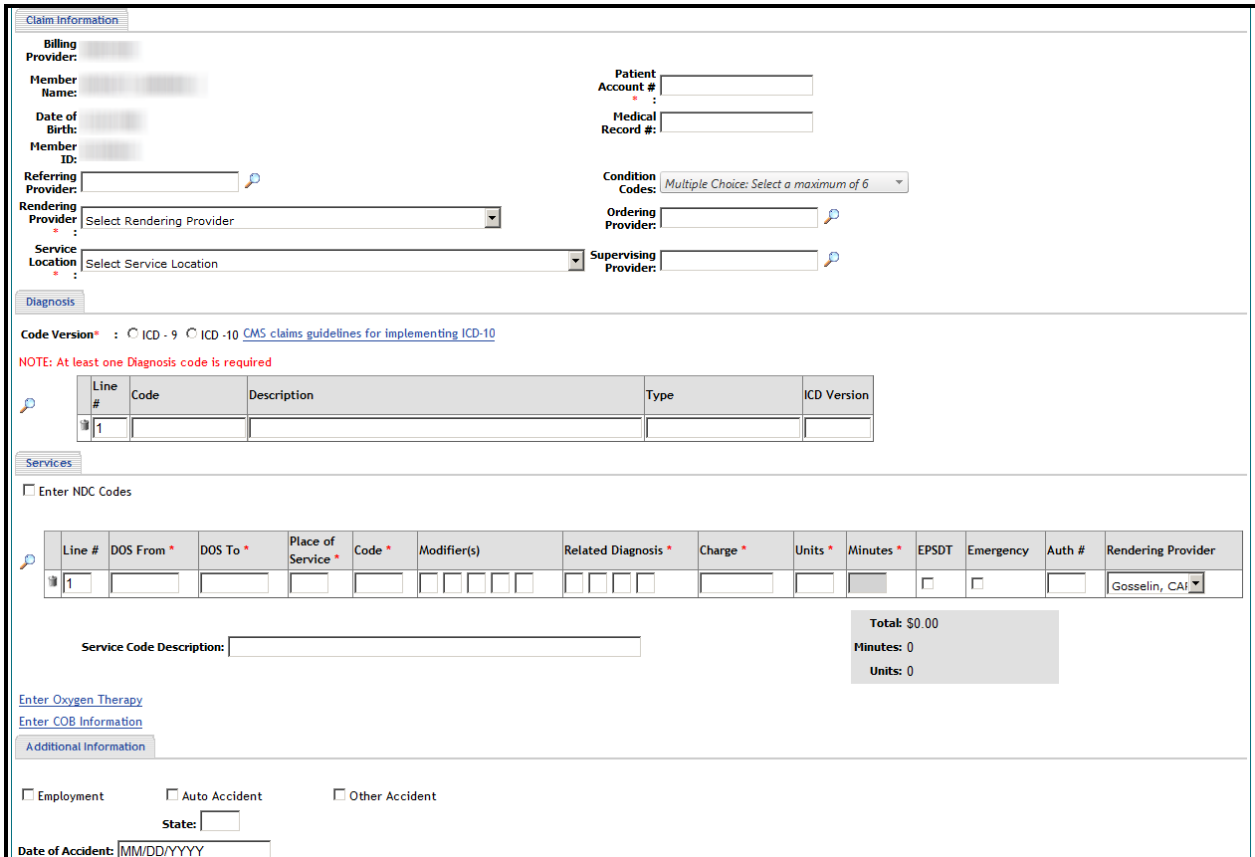
- b. **If the member is not returned in the search**, click the **Cancel** button to reset and clear all the values entered in the find member search. See the hint under Step 3.



**Figure 4-5: Member Search Results**

## 4.2 Step 2 – Professional Claim Submission


Upon the selection of the member for a professional claims submission, the Claim Wizard – Professional Claim screen (CMS 1500) will populate. There are four sections associated with this screen as shown in [Figure 4-6](#) below: **Claim Information**, **Diagnosis**, **Services**, and **Additional Information**.



**Figure 4-6: Professional Claim**

Input fields with a red asterisk (\*) are required. An error message will be displayed if these values are left blank.

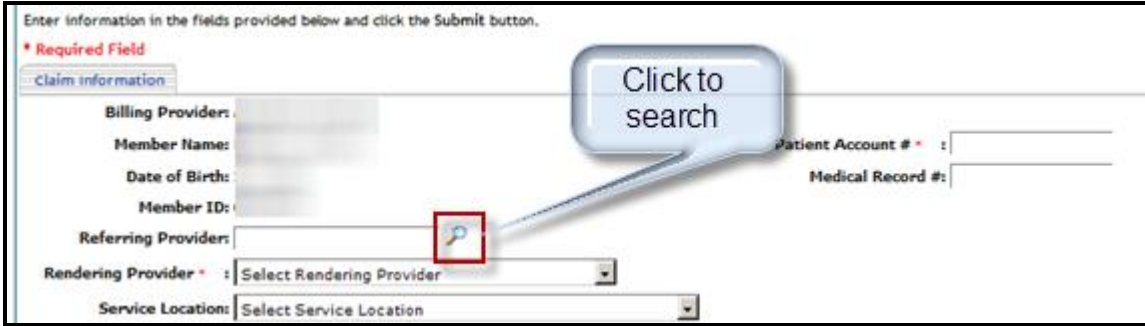
**NOTE:** Always tab through fields on a single line (such as in the Services Section) to ensure proper completion.

Some claim items, like diagnosis codes, may have additional lines added. To add more lines, tab through the last line. In order to delete a line, select the option button  in front of the line.

Proceed through the sections below to complete this screen:

#### 4.2.1 Complete the Claim Information Section

The Claim Information section is shown in [Figure 4-7](#) below.



Enter information in the fields provided below and click the Submit button.

\* Required Field


claim information

Billing Provider: [Redacted]

Member Name: [Redacted]

Date of Birth: [Redacted]

Member ID: [Redacted]

Referring Provider: [Redacted]  Click to search

Rendering Provider \* : Select Rendering Provider [Drop-down arrow]

Service Location: Select Service Location [Drop-down arrow]

Patient Account # \* : [Redacted]

Medical Record #: [Redacted]

**Figure 4-7: Claim Information**

Use the tips below to complete this section:


[Table 1](#) below supplies descriptions and instructions for each field shown in [Figure 4-7](#) above. Use it to complete this section:

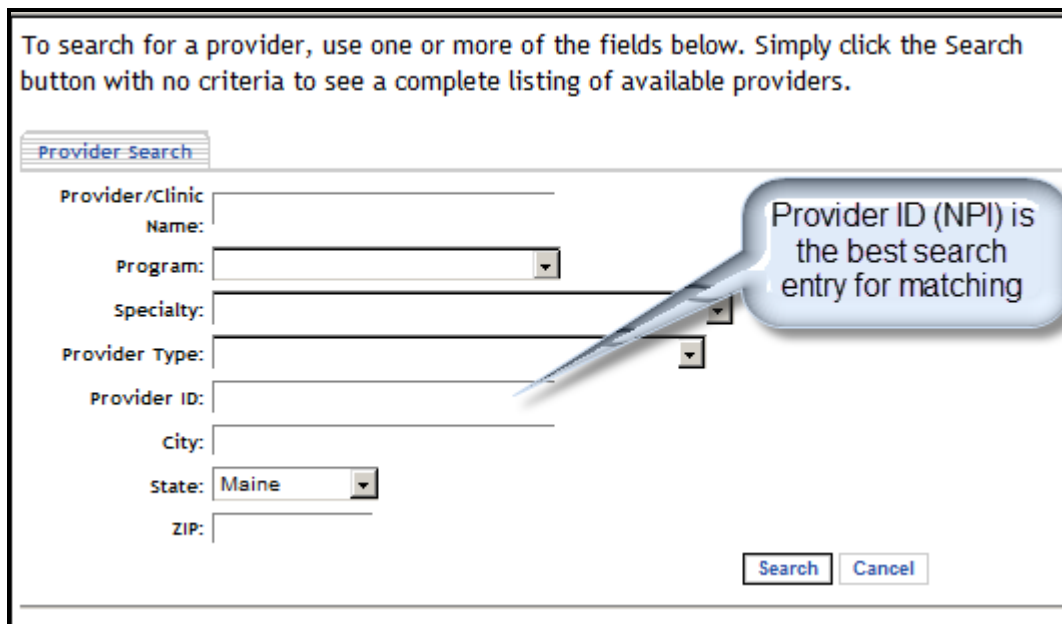
**Table 1: Claim Information**

Field Name	Field Description
Referring Provider	<p><b>This field is required.</b></p> <p>Enter the referring physician by using the look up function. For additional instructions on how to use the provider look up function go to <a href="#">Section 4.2.1.1: Provider Look Up Function</a>.</p>
Rendering Provider	<p><b>This field is required.</b></p> <p>Enter the rendering provider by selecting the drop-down arrow and clicking on the appropriate option.</p> <p>The drop-down selection for this field will show a list of providers if there is more than one rendering provider option.</p>
Service Location	<p><b>This field is required if the provider is enrolled with more than one service location.</b></p> <p>Enter the billing provider service location by selecting the drop-down arrow and clicking on the appropriate option.</p> <p>The drop-down selection for this field will show a list of locations if the provider has more than one service location.</p>

Field Name	Field Description
Patient Account #	<b>This field is required.</b> The alpha numeric information assigned by the provider that is returned on any Remittance Advice (RA).
Medical Record #	The alpha numeric information assigned by the provider.

### 4.2.1.1 Provider Look Up Function

To access the provider look up function, click on the  icon next to a provider information field. The **Provider Search** screen will populate with provider search criteria as depicted in [Figure 4-8](#) below.



**Figure 4-8: Provider Search**

**NOTE:** To search for a provider, use one or more of the fields or click the search button with no criteria to see a complete listing of available providers.

- Enter the search criteria.
  - Drop-down boxes are used to select values for **Specialty**, **Provider Type**, **Program**, and **State**.
  - Some lists may have a blank line to allow searching all data.
  - All other fields must match exactly for this search function.
  - Click **Cancel** to cancel the search and go back to the Professional Claim Wizard, as referenced in [Section 4.2: Step 2 – Professional Claim Submission](#).
- Click the **Search** button. The results will be listed at the bottom of the **Provider Search** page, under **Search Results**.
- The results will display the provider's name, provider ID, address, phone number, specialty, and provider type, as depicted in [Figure 4-9](#) below.
- Select the radio button next to the **Provider Name** and click **continue** to return to the **Claim Information** page.

Name	Provider ID	Address	City, State, ZIP	Phone #	County	Primary Specialty	Provider Type
						OBSTETRICIAN AND GYNECOLOGIST	51- Physician

Continue

Figure 4-9: Provider Search Results

## 4.2.2 Complete the Diagnosis Section

Complete the Diagnosis section as depicted in [Figure 4-10](#) below. The diagnosis section is used to enter the diagnoses associated with the services provided to the member.

**NOTE:** Effective on 10/1/2015, providers will be able to enter both ICD-9 and ICD-10 based claims. The following changes to the portal will be available:

- ICD-9 and ICD-10 radio buttons will be provided in diagnosis code session. Selection of one radio button will be required to differentiate between ICD-9 and ICD-10 based claims. A diagnosis code cannot be entered before one of the ICD radio buttons is selected. After a diagnosis code is entered, the ICD radio button selection cannot be changed.
- A link called 'CMS Claims Guidelines for Implementing ICD-10' will be available to the right of the ICD radio button selection if additional ICD-10 information is needed.

Diagnosis

Code Version\* : ☐ ICD - 9 ☐ ICD - 10 [CMS claims guidelines for implementing ICD-10](#)

NOTE: At least one Diagnosis code is required

Line #	Code	Description	Type	ICD Version
1				

Figure 4-10: Professional Diagnosis Section

Use the bulleted tips below to complete this section:

- There are four fields in the Diagnosis section: **Line #**, **Code**, **Description**, and **Type**. The only editable field is **Code** (see note above about the ICD code selection).
- To add a new line, hit tab at the end of the last line and a new line will appear. The **Line #** will increase as each line is added. Up to 12 diagnosis codes may be submitted.
- To make the **Description** and **Type** appear, enter the code in the first field and hit tab to proceed to the next two fields.
- The first line entered will be the primary diagnosis and all additional lines will be considered secondary.


**NOTE:** For most claims, services prior to and on or after 10/01/2015 need to be billed on separate claims. For claims with dates of service of 10/01/2015 and forward, use the appropriate ICD-10-CM code. For claims with dates of service prior to 10/01/2015, use the appropriate ICD-9-CM code, with the following exceptions:

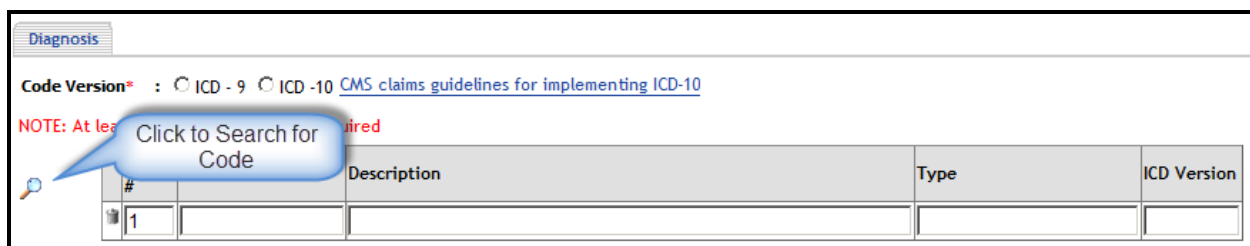
- Claims with services prior to and on or after 10/01/2015 can be billed on the same claim form if the claim is a DMEPOS claim. If the DMEPOS claim has a from date prior to 10/01/2015 and a

through date on or after 10/01/2015, the entire claim is billed using ICD-9-CM codes based on the from date of service.

- Claims with anesthesia procedures that begin on 09/30/2015, but end on 10/01/2015, are to be billed with ICD-9 diagnosis codes and use 09/30/2015 as both the FROM and THROUGH date.

#### 4.2.2.1 Diagnosis Search Function

To access the **Diagnosis Codes** search function, click on the  icon next to the **Line #** and a new search window will open-see [Figure 4-11](#) below.



#	Description	Type	ICD Version
1			

**Figure 4-11: Diagnosis Code Search**

1. Enter any part of the description of the code in the **Description** field.

**HINT:** MIHMS will match exactly the sequence of characters entered in the search criteria. For example: if no match is found for “Sleep Disorder” try just “sleep”. Conversely, using just the word “disorder” may be too broad and result in a longer list.

2. Click the **Search** button to retrieve a list of results. The system will look for the text entered regardless of where it falls in the description.
  - a. To start over, click the **Reset** button to clear the **Description** field.
3. The diagnosis search will return a list of **Code IDs**, **Descriptions**, **Effective** and **Term dates**, and **ICD Versions**, as shown in [Figure 4-12](#) below. Click any **Code ID** link to populate the Code ID to the **Diagnosis** section.

**NOTE:** Effective on 10/01/2015, the Code ID displayed in the search field will be based on the ICD-radio button selection made as part of the steps listed in section [4.2.2](#). For example, if a user chose the ICD-10 radio button, only ICD-10 codes will display in the Code ID field.

4. Once the Code ID is displayed, tab through to populate the description and type. A new line will be presented if additional codes need to be entered.
  - a. Additional blank lines will not affect the processing of the claim.

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To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

**Diagnosis Codes**

Description:

Code ID	Description	Effective Date	Term Date	ICD Version
<a href="#">F10.180</a>	Alcohol abuse w/alc-ind anxiety disorder	10/1/2013		10
<a href="#">F10.181</a>	Alcohol abuse w/alc-ind sexual dysfunction	10/1/2013		10
<a href="#">F10.182</a>	Alcohol abuse w/alc-induced sleep disorder	10/1/2013		10

**Figure 4-12: Diagnosis Code Search Results**

**NOTE:** Ambulance claims must include a diagnosis code. For dates of service prior to 10/01/2015, use ICD-9 code 780.99 (Other General Symptoms). For Dates of Service of 10/01/2015 and forward, use the appropriate ICD-10 code: R45.84 (anhedonia) or R68.89 (other general symptoms and signs).

### 4.2.3 Complete the Services Section

Complete the Services Section as depicted in [Figure 4-13](#) below.

**Services**

Enter NDC Codes

Line #	DOS From	DOS To	Place of Service	Code	Modifier(s)	Related Diagnosis	Charge	Units	Minutes	EPSDT	Emergency Auth #	Rendering Provider	NDC	Unit of Measure	Qty/Units	Rx Number
1																

Click to search

Total: \$0.00  
Minutes: 0  
Units: 0

**Figure 4-13: Professional Services Section**



This section of the claims screen is used to enter the Services rendered to the member that will be included in the claim submission. The fields and links associated with this section are summarized in [Table 2](#) below.

**NOTE:** Additional information on covered services can be found in the *MaineCare Benefits Manual*.

If a member has a coverage code of "Spenddown", the spenddown letter must be obtained and attached to the claim. Please see [Section 4.3.4: Upload Attachments](#) for more information. Spenddown claims are entered via Direct Data Entry (DDE) according to the usual professional claim entry instructions in this guide in [Section 4: Form Entry: Claim Submission](#).



**Table 2: Claim Service Section**

Field Name	Field Description
<b>Enter NDC Codes</b>	<p>Select the <b>Enter NDC Codes</b> check box to enter a service line for physician administered drugs. This action will make the following fields on the service line editable:</p> <ul style="list-style-type: none"> <li>• <b>NDC</b></li> <li>• <b>Unit of Measure</b></li> <li>• <b>Qty/Units</b></li> <li>• <b>Rx Number</b></li> </ul> <p>The MIHMS Health PAS Online Portal allows providers to query procedure code/NDC combinations and NDC rebate information by specific dates. The portal will then display valid J-Codes and NDC combinations for MaineCare. More information about this functionality is included as <a href="#">Appendix C</a> to this document.</p>
	Click this icon to delete a service line.
<b>Line #</b>	<p>This is a system-generated field used to number each service line added by the user.</p> <p>To add a new service line, hit tab at the end of the last line and a new line will appear.</p>
<b>DOS From/DOS To</b>	<p><b>This field is required.</b></p> <p>Enter the beginning and ending dates of the period in which the service was provided.</p> <p>Dates must be entered in MM/DD/CCYY format. For example, February 14, 2008 would be entered as "02/14/2008".</p>
<b>Place of Service</b>	<p><b>This field is required.</b></p> <p>Enter the appropriate two-digit place of service code(s).</p> <p>Use a place of service code to identify the location for each item used or service performed.</p> <p><b>Durable Medical Equipment and Supplies Providers:</b> Use the Place of Service code where the member resides.</p> <p>See <a href="#">Appendix A</a> for a full code list.</p>
<b>Code</b>	<p><b>This field is required.</b></p> <p>This field represents the CPT code for the service. Enter the code in this field if known or use the  link to perform a code search. The search link is located in front of the Service Line as shown in <a href="#">Figure 4-13</a>.</p>

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Field Name	Field Description
<b>Modifier(s)</b>	<p>CPT code modifiers provide additional details regarding various services.</p> <p>CRNAs bill with the QZ modifier for a CRNA service without medical direction by a physician and a QX for CRNA service with the medical direction by a physician.</p> <p>Repair/Replacement Procedures must be billed with the RA or RB modifiers as appropriate.</p> <p>Bi-lateral procedures require the code with the 50 modifier on one claim line. (Procedure is reimbursed at 150% of the allowed amount.)</p> <p>Family Planning services must be billed using "FP" modifier. Family Planning services are those provided to prevent or delay pregnancy or to otherwise control family size. Counseling services, laboratory tests, medical procedures and pharmaceutical supplies and devices are covered if provided for family planning purposes.</p> <p>State Supplied Vaccines require the use of the "SL" modifier on both the administration code and the vaccine code.</p> <p>Ambulance providers should insert the H9 modifier before the origin/destination code, when appropriate. In the Modifier Box, enter the appropriate two letters for the transport's place of origin and destination. See <a href="#">Appendix B</a> for a list of these codes and their definitions.</p>
<b>Related Diagnosis</b>	<p><b>This field is required.</b></p> <p>The Related Diagnosis field corresponds with the line number or numbers in the Diagnosis section above that support(s) the service line. Up to 12 diagnosis codes are allowed; therefore, double digit entries are allowed in the related diagnosis section.</p>
<b>Charge</b>	<p><b>This field is required.</b></p> <p>Enter the total dollar amount charged for the services.</p> <p>The system will add the dollar sign (\$) and will assume two decimal places unless specifically entered by the user.</p>

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Field Name	Field Description
<b>Units</b>	<p><b>This field is required.</b></p> <p>Enter the number of times the service being billed was performed.</p> <p><b>NOTE:</b> For anesthesia claims, the units will default to one (1). The code range is 00100 – 01999. For anesthesia services, the provider must enter the number of anesthesia minutes in the Minutes field.</p> <p>Units must be whole numbers.</p> <p>Do not use decimal points or fractions (e.g. 1.5 or 1/2)</p> <p>In cases where services provided include less than a whole unit of service, the unit shall be rounded up only if equal to or greater than fifty percent (50%) of the unit of service (e.g. 1.5 units of service equals 2 units of service rounded up; 1.4 units of service equal 1 unit of service). The procedure code for the smallest unit of service must be used.</p> <p>Specific provisions in any other Chapters or Sections of this manual, or in the CMS 1500 Billing Instructions Guide, will supersede this rounding requirement.</p> <p>The CMS 1500 Billing Instructions Guide may be found at the following link:</p> <p><a href="https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx">https://mainecare.maine.gov/Billing%20Instructions/Forms/Publication.aspx</a></p>
<b>Minutes</b>	<p><b>This field is required for anesthesia services.</b></p> <p>Enter the number of anesthesia minutes for the service being billed.</p> <p><b>NOTE:</b> For anesthesia claims, the units will default to one (1). The code range is 00100– 01999. The Minutes field will appear greyed out until an anesthesia code is entered.</p>
<b>Early Periodic Screening Diagnosis Treatment (EPSDT)</b>	<p>If the service the user is billing for is associated with EPSDT enter “Y” in this field.</p> <p>This field defaults to “N”.</p>
<b>Emergency</b>	<p>For services delivered during an emergency situation that typically require Prior Authorization, a “Y” must be entered in this box.</p> <p>An appropriately entered “Y” submitted in this field will prevent a copay from being deducted for services subject to a copay.</p> <p><b>NOTE:</b> Refer to Chapter I of the MaineCare Benefits Manual for a list of services exempt from copays:</p> <p><a href="http://www.maine.gov/sos/cec/rules/10/ch101.htm">http://www.maine.gov/sos/cec/rules/10/ch101.htm</a></p>
<b>Auth #</b>	<p>Required for services where multiple Prior Authorizations (PAs) exist for the same date, service, member and provider. Enter the PA number issued by the authorizing unit for the services or supplies being billed. Bill only one PA number on each claim. A PA number entered must exactly match the authorization number in MIHMS including both alpha and numeric characters.</p>

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Field Name	Field Description
<b>Rendering Provider</b>	<p>This field captures the provider that rendered the service for which the claim is being submitted.</p> <p>Select by clicking on the drop-down arrow and choosing the appropriate provider.</p> <p>Providers billing for interpreter services need to put the healthcare provider's rendering ID on the claim.</p> <p>A claim form may only have one (1) rendering NPI. The same rendering provider could bill multiple services on a single claim.</p>
<b>National Drug Code (NDC)</b>	<p>The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits.</p>
<b>Unit of Measure</b>	<p>Enter the NDC unit of measurement. The unit of measurement codes are:</p> <ul style="list-style-type: none"> <li>• F2- International Unit</li> <li>• GR- Gram</li> <li>• ME- Milligram</li> <li>• ML- Milliliter</li> <li>• UN- Unit</li> </ul>
<b>Qty/Units</b>	<p>NDC units are based upon the numeric quantity administered to the patient and the unit of measurement.</p> <p>Enter the actual metric decimal quantity administered in this field.</p>
<b>Rx Number</b>	<p>The Rx Number field should be used when the dispensing of the drug was done with a prescription number or when the dispensed drug involves the compounding of two or more drugs and there is no prescription number.</p> <p>If there is no prescription number, a "link sequence number" is reported, which is a provider-assigned number that is unique for the claim. The link sequence number matches the components, similar to the prescription number.</p>
<b>Service Code Description</b>	<p><b>This field will automatically populate.</b></p> <p>Description of the service code entered for the specified service line.</p>
<b>Total</b>	<p><b>This field will automatically populate.</b></p> <p>This field displays the total dollar for all service lines entered.</p>
<b>Minutes</b>	<p><b>This field will automatically populate.</b></p> <p>This field displays the total number of minutes for all service lines entered.</p>
<b>Units</b>	<p><b>This field will automatically populate.</b></p> <p>This field provides a sum of the number of service units billed at the service line level that is automatically calculated.</p>

**NOTE:** When a service code is entered, the description will appear in the **Service Code Description** box. The Total Price and Total Units will be totaled in the grey area next to the **Service Code Description** field; as shown in [Figure 4-13](#) above.

### 4.2.3.1 CPT Search Function

The screenshot shows the 'Services' section of the Health PAS Online interface. A table with columns: Line #, DOS From, DOS To, Place of Service, Code, Modifier(s), Related Diagnosis, Charge, Units, Minutes, EPSDT, Emergency, Auth #, and Rendering Provider is visible. A callout box points to a magnifying glass icon next to the 'Line #' column header, with the text 'Click to search for code'. Below the table, there is a 'Service Code Description' field and a grey box showing 'Total: \$0.00', 'Minutes: 0', and 'Units: 0'. Links for 'Enter Oxygen Therapy' and 'Enter CCB Information' are also present.

**Figure 4-14: CPT Search Function Icon**

To search for a **Service Code**, click the  button next to the **Line**, as shown in [Figure 4-14](#) above and a new search window will open. See [Figure 4-15](#) below.

The screenshot shows the 'Service Codes' search window. It contains instructions: 'To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.' Below the instructions is a 'Description:' text input field with 'Search' and 'Reset' buttons. At the bottom is a 'Close Window' button.

**Figure 4-15: CPT Search Function**

1. Enter any part of the description of the code in the **Description** field.

**HINT:** MIHMS will match exactly the sequence of characters entered in the search criteria. For example: if nothing is found for “sinus surgery” try just “sinus”. Conversely, using the word “surgery” may be too broad and result in a longer list.

2. Click the **Search** button to retrieve a list of results. The system will look for the entry regardless of where it falls in the description.
  - a. To start over, click the **Reset** button to clear the **Description** field.

- The search will return a list of **Service Codes**, their **Description**, and **Effective** and **Term Date**. Single-click any **Service ID Code** link to return it to the **Code** field; as shown in [Figure 4-16](#) below.

To use a code, click on its hypertext link. To search for a specific code, enter part of its description in the field provided and click the Search Button. Click the Reset button to clear the field and return all codes.

**Service Codes**

Description:

**Click code ID**

Service Code	Description	Effective Date	Term Date
<a href="#">S9024</a>	Paranasal sinus ultrasound	1/1/2000	
<a href="#">S2342</a>	Nasal endoscopy postop debride aftr sinus surg	1/1/2002	

**Figure 4-16: CPT Search Function Results**

#### 4.2.4 Enter COB Information

The user may enter the information for Coordination of Benefits (COB) by selecting the **Enter COB Information** link below the Service Code area.

- The COB information may be entered either by Claim or by Service Line for any external totals to be applied as COB. Information must be entered at the Service Line level when available on the Explanation of Benefits (EOB). When possible, enter detail at the Line Level for more accurate claims processing, as shown in [Figure 4-17](#) below.

Enter External Totals to be applied as COB

Enter Medicare: ☐ by Claim ☒ by Service line

Choose this option for Medicare claims

Line #/Total	DOS	Allowed Amt	Paid Amt	Deductible Amt	Coinsurance Amt	Act Code
Total Medicare						
1						

Enter Commercial: ☐ by Claim ☒ by Service line

Choose this option for TPL claims

Line #/Total	Service Code	DOS	Allowed Amt	Paid Amt	Deductible Amt	Coinsurance Amt
Total Commercial						
1						

**Figure 4-17: COB Information**

- Choose the Medicare or Commercial option as appropriate- see [Figure 4-17](#) above.
  - If entering claims when Medicare C is primary, choose the Medicare option.
  - If entering claims for Third Party Liability (TPL), choose the Commercial option
- The allowed amount should equal the sum of paid, deductible, and coinsurance amounts for both TPL and Medicare. The coinsurance amount will include copays.
- The Paid Date must be entered on the Coordination of Benefits screen when the claim is submitted as a secondary claim to MaineCare. Claims with no Paid Date will be denied.
- Click **Submit** to enter COB information.

- **Note:** When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.

**NOTE:** Enter detail at the line level for more accurate claims processing.

If entering COB information, the **Paid Amt**, **Deductible Amt**, and **Coinsurance Amt** fields must be populated. If the paid, deductible, or coinsurance amount is \$0.00, enter a “0” or “0.00” into the field. The online portal will not allow the manual entry of the “\$” symbol when entering dollar amounts. Alternately, the provider may “tab through” the fields, and they will automatically populate with \$0.00.

If there is no Medicare Action Code (MAC) on the EOB, leave this field blank. If a MAC is noted on the EOB, the code(s) must be entered.

When submitting the EOB for Medicare Part C, the user must write “Medicare” on the top of the EOB for accurate claims processing.

When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.

## 4.2.5 Complete Oxygen Therapy Information

To enter Oxygen Service Information, click the **Enter Oxygen Therapy** link and then enter the information in the fields provided- see [Figure 4-18](#) below.

- Click **Add** to add the information to the table.
- Edit the value by selecting the **Edit** icon;
- Modify the line as desired and click the **Save** button.

**NOTE:** The **Save** button appears when the **Edit** icon is selected.

- Delete the value by clicking the **Delete** icon.

Test Condition Code:

Treatment Period Count:

UPN Code :

UPN Type :

Last Certification Date\* :

Oxygen Findings:

☐ 1 - Dependent edema suggesting congestive heart failure

☐ 2 - Pulmonale on Electrocardiogram (EKG)

☐ 3 - Erythrocythemia with a hematocrit greater than 56 percent

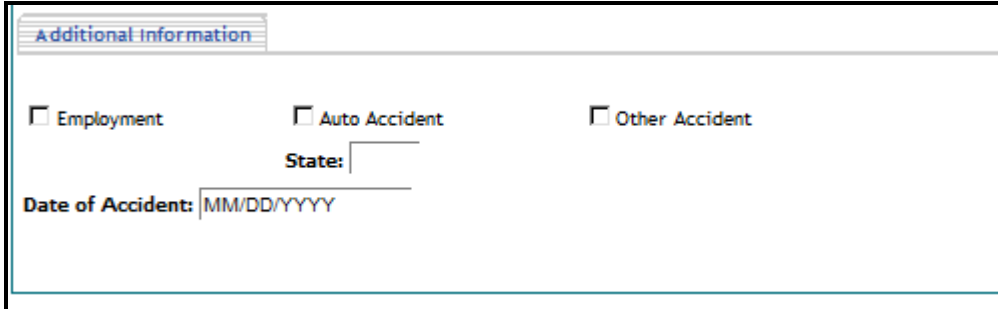
Oxygen Services Summary

E	D	Line No.	CPI Code	DOS	Blood Gas Qnty.	Cert Type	O2 Saturat
		1	D7952	9/20/2013 - 9/20/2013		I	

**Figure 4-18: Oxygen Therapy**

## 4.2.6 Complete the Additional Information Section

Complete the Additional Information section for the claim submission, shown in [Figure 4-19](#) below, if applicable. The Additional Information section is used to enter information related to any third party liability associated with the claim.



**Figure 4-19: Professional Additional Information Section**

If applicable, select the check box next to the correct type of accident associated with the claim: **Employment**, **Auto Accident**, or **Other Accident**. If the user selects a check box, enter the two-letter abbreviation of the state in which the accident took place.

Enter the date of the accident in eight-digit format (MM/DD/YYYY).

## 4.2.7 Submit the Claim

When all the claim information has been entered, click **Submit** to submit the claim. Any errors in the application will be indicated at the top of the page in red text and must be corrected before the claim can be submitted.

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate.

## 4.3 Step 3 – The Claim Wizard Confirmation Screen

Upon the successful submission of the claim, a Claim Wizard Confirmation screen will populate as seen in [Figure 4-20](#) below.

Claim View page.' A callout bubble points to the 'Claim View' link with a button labeled 'Claim View'. At the bottom, there are five buttons: 'Adjudicate Claim', 'Edit Claim', 'Upload Attachments', 'Print Attachment Cover Sheet', and 'New Claim'." data-bbox="116 604 820 788"/>

**Figure 4-20: Claim Confirmation Screen**

The **Claim ID** is automatically displayed on the confirmation screen. The Claim Wizard Confirmation screen also presents the following options:

- **Claim View:** Used to view a summary of the information that was entered into the claim (claim summary).



- **Adjudicate Claim:** Processes the submitted claim against the business rules and readies it for finalization.
- **Edit Claim:** Used to **change** claim information.
- **Upload Attachment:** Used to **attach** any **additional** information that is required to support the claim submission. Uploaded documents must be uniquely named. Without a unique name, the document will not overwrite another document of the same name. The result is the original attachment will now be inappropriately attached to the current claim.
  - Claims with COB information must have a corresponding EOB attached. When submitting a Medicare Part C EOB, be sure to write “Medicare” on the top of the EOB.
  - Spenddown letters should be attached for each claim where the member has a coverage code of “Spenddown” for that particular date of service.

***NOTE:** Spenddown claims are entered via DDE according to the usual professional claim entry instructions in this guide in [Section 4: Form Entry: Claim Submission](#).*

- **Print Attachment Cover Sheet:** Select to print a cover sheet for the attachment.
- **New Claim:** Used to create a new claim.

### 4.3.1 Claim View

Clicking the **Claim #** hyperlink reveals the original claim. [Figure 4-21](#) below is an example of a claim view.

**Claim Summary**

Claim Type: 1500 Status: **OPEN**  
Claim #: [REDACTED] Patient Account #: 123  
Member ID: [REDACTED] Medical Record #: [REDACTED]  
Member Name: [REDACTED] Service Provider: [REDACTED]  
Address: [REDACTED] Pay To Provider: [REDACTED]  
Dates of Service: 10/1/2014 – 10/1/2014 Check #: [REDACTED]  
Date Processed: 10/2/2014 Check Date: [REDACTED]  
Service Location: [REDACTED] ☐ Missing Information Indicator

**Reimbursement Detail**

Claim Total: \$75.00	Copay Applied: \$0.00
Allowed Amt: \$0.00	Deductible Applied: \$0.00
Eligible Amt: \$0.00	Coinsurance Applied: \$0.00
Paid Amt: \$0.00	Disallowed: \$0.00
Interest Days: 0	Cost of Care: \$0.00
Withhold Amt: \$0.00	Addtl Responsibility: \$0.00
Paid(net Withhold) Amt: \$0.00	Total Patient Responsibility: \$0.00
COB Allowed: \$0.00	
COB Paid: \$0.00	
Refund Amt: \$0.00	

**Diagnosis Codes**

Code	Description
I10	Essential (Primary) Hypertension

< Prev Next >

**Services**

Service Line	Dates of Service	Service Location	Service Code	Modifier(s)	Billed Units	Billed Amount	Paid Amount	Detail
1	10/1/2014 – 10/1/2014	11	99212		1.00	\$75.00	\$0.00	<a href="#">Details</a>

< Prev Next >

**Remittance Comments**

No comments were found for this claim.

**Claim Edit**

No Edits were found for this claim.

**Details Link**

[Return to Claim Status](#) [Adjudicate Claim](#) [Reverse](#)

Figure 4-21: Claim View

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View the details of a specific service line by clicking on the **Details** link at the end of that service line as shown above in [Figure 4-21](#). An example of the service line detail is depicted in [Figure 4-22](#) below.

The screenshot displays the 'Service Line Detail' page. At the top, there is a 'Claim Summary' tab. Below it, the 'Claim #' is shown with a redacted value, and the 'Status' is 'OPEN' in orange text. Other fields include 'Health Plan ID:', 'Member Name:', 'Dates of Service: 8/29/2012 - 8/29/2012', and 'Date Processed: 8/30/2012'. The 'Service Line Detail' tab is active, showing 'Service Line: 1' and 'Status:'. Below this, it lists 'Date of Service From: 8/29/2012', 'Date of Service To: 8/29/2012', and 'Service Location: 11'. The 'Service Code' is '99212 - office outpatient visit 10 minutes'. Other fields include 'Emergency:', 'NDC Codes:', 'Modifiers:', 'Billed Unit(s): 1.00', 'Auth ID:', 'UM Approved Unit(s):', 'Billed Amt: \$75.00', 'Allowed Amt: \$0.00', 'Eligible Amt: \$0.00', 'Paid Amt: \$0.00', 'Withhold Amt: \$0.00', 'Paid(net Withhold) Amt: \$0.00', 'Cost of Care Amt: \$0.00', 'Patient Responsibility: \$0.00', and 'Pre-Paid: \$0.00'. There is a checkbox for 'Missing Information Indicator'. At the bottom, there is a 'Remittance Comments' section with the text 'No comments were found for this service line.' and a 'Return to View Claim' button.

**Figure 4-22: Service Line Details**

After viewing the claim, the user may Adjudicate or Reverse it, Add Attachments, or Return to Claim Status by using the buttons at the bottom of the screen as shown in [Figure 4-23](#) below.

The screenshot shows a row of four buttons: 'Return to Claim Status', 'Adjudicate Claim', 'Reverse', and 'Add Attachments'.

**Figure 4-23: Claim Standard Buttons**

**NOTE:** A claim must be in a final (Paid) status before it can be reversed.

### 4.3.2 Adjudicate Claim

The **Adjudicate Claim** button on the confirmation page initiates the claim adjudication process and sends the claim through predefined edits for real-time claims processing.

By viewing the status of the adjudication, the user can see if a claim has been successfully processed. If the claim fails to adjudicate, an error message will appear that reads, "Warning: There are outstanding

edits” as shown in [Figure 4-24](#) below. The edits that caused the claim to fail adjudication will display under the Outstanding Edits header- see [Table 3](#) below for a list of Claim Statuses.

A claim on the portal can be adjudicated up to 10 times. The message at the top of the screen reading "Number of online adjudication attempts: x" keeps a running count.

Claims may have edits posted that indicate if the edit is a warning, denial, or pend. **A warn edit does not prevent a claim from paying.**

The screenshot displays the 'Adjudicate Claim' screen. At the top, a red warning message states 'Warning: There are Outstanding Edits' with a callout bubble labeled 'Warning'. Below this, the 'Number of online adjudication attempts: 1' is shown. The 'Claim Information' section includes fields for Claim Type (1500), Claim #, Log Date, Member ID, Member Name, Address, and Dates of Service (9/23/2013 - 9/23/2013). The 'Billing Provider' section includes Patient Account #, Medical Record #, Prior Auth, Date of Birth, Rendering Provider, and Referring Provider (NO PROVIDER). The 'Outstanding Edits' table has columns for Line #, Edits, Description, Status, and Category. A single edit is listed: Line # 1, Edits 150, Description 'No contract term found for service', Status DENY, and Category CONTRACT. A callout bubble labeled 'Click to Edit' points to the 'Edits' column. At the bottom, there are buttons for 'Edit Claim', 'Add Attachments', 'Print Attachment Cover Sheet', and 'New Claim'.

**Figure 4-24: Adjudicate Claim**

After adjudication, the user may add attachments by selecting **Add Attachments**- see [Figure 4-25](#) below.

The screenshot shows a horizontal bar with four buttons: 'Return to Claim Status', 'Adjudicate Claim', 'Reverse', and 'Add Attachments'. The 'Add Attachments' button is highlighted with a red rectangular box.

**Figure 4-25: Add Attachments**

### 4.3.3 Edit Claim

Clicking the **Edit Claim** button opens the claim that was just submitted and offers the option to edit the claim and add or delete parts of the claim as needed before adjudicating the claim again.

Upon completion, three buttons offer further options: **Back**, **Save**, **Adjudicate**, as shown in [Figure 4-26](#) below.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.

The screenshot shows three buttons arranged horizontally: 'Back', 'Save', and 'Adjudicate'.

**Figure 4-26: Claim Back, Save, Adjudicate**

### 4.3.4 Upload Attachments

Attachments may be uploaded from the **Claims Status** window by clicking the **Add Attachments** button. A new window will appear as shown in [Figure 4-27](#) below. For information on navigating to the Claim Status window, see [Section 5: Claim Status](#).

The screenshot shows the 'Add Attachments' window. At the top, it says 'You Are Here: Add Attachments'. Below this, there are fields for 'Claim Number:', 'Provider Name:', 'Member Name:', and 'Date of Service:'. To the right, it shows 'Type: 1500' and 'Claim Status: PEND'. A tab labeled 'Attachments' is selected. Below the claim information, there is a 'Type of Attachment:' dropdown menu with 'X-ray' selected. A callout bubble points to this dropdown with the text 'Drop-down Menu'. Below the dropdown, it says 'File Format: Valid file formats are: GIF, JPEG, MS Excel, MS Word, PDF, TIFF'. There is a text input field and a 'Browse...' button. A callout bubble points to the 'Browse...' button with the text 'Browse Local Machine'. At the bottom of the window are 'Attach' and 'Cancel' buttons.

**Figure 4-27: Upload Attachments**

Claim information is pre-populated on the top of the page. To add an attachment, follow the steps below:

1. Click the drop-down menu to select the **Type of Attachment** that will be added.
2. Select the **Browse** button to locate the file on the local computer. All supporting document files must be in one of these formats: GIF, JPEG, MS Excel (.xls), MS Word (.doc), PDF, and TIFF.
3. Click the **Attach** button when the file to upload is listed in the **Browse** field.
4. Attachments may be uploaded through the portal for claims previously submitted via EDI or paper by searching for the matching claim in Claims Status and uploading a scanned attachment directly to the claim. See [Section 5: Claim Status](#) for more information on searching for claims by claim status. Attachments should be submitted on the same day. If appropriate attachment is not present when a claim is being reviewed, it will deny.
  - If the user is unable to upload required attachments, claims should then be submitted on paper with the appropriate attachment.

**NOTE:** If users are unable to upload electronic copies of attachments, fill out the **Cover Sheet for Claims** found on the *Provider Page>Provider Documents>Forms>Claims*. Be sure to include the **Claim number** provided on the confirmation screen. Send the cover sheet along with all mailed documents. If the appropriate attachment is not present when the claim is reviewed, the claim will deny.

**Mail to:**

Claims Unit- Attachments  
Office of MaineCare Services  
11 State House Station  
Augusta ME 04333-0011

## 5. Claim Status

To check the status of a claim, follow the steps below:

1. Select the **Claim Status** link under the **Form Entry** heading to access the claim status screen. See [Figure 5-1](#) below.

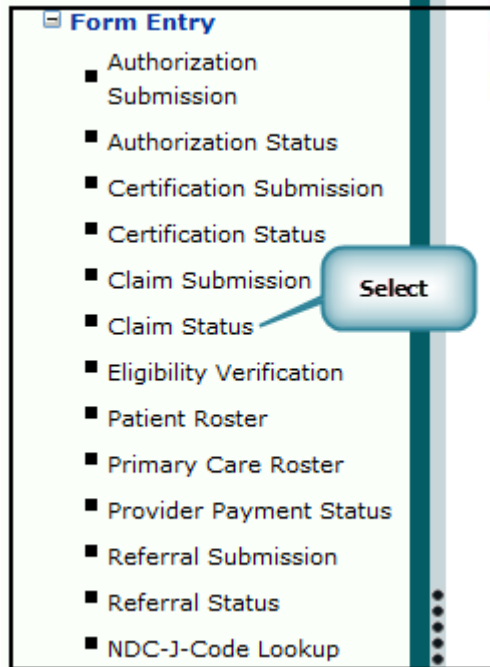


Figure 5-1: Form Entry

1. Select the proper provider from the **Billing Providers** drop-down menu. Claims associated with the selected Billing Provider will be displayed below the drop-down menu, under claim status- see [Figure 5-2](#) below for reference.

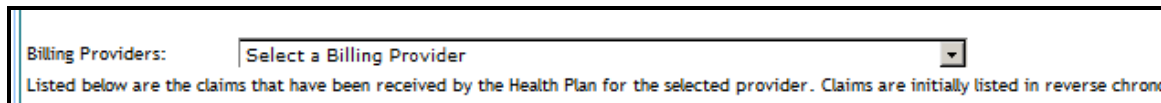


Figure 5-2: Select Provider

2. The search results for that Billing Provider are shown in the order of the newest to the oldest claims. Clicking on any underlined column heading will sort the lines according to the values in that column. To view claims in greater detail click the **Claim #** link as shown in [Figure 5-3](#) below.

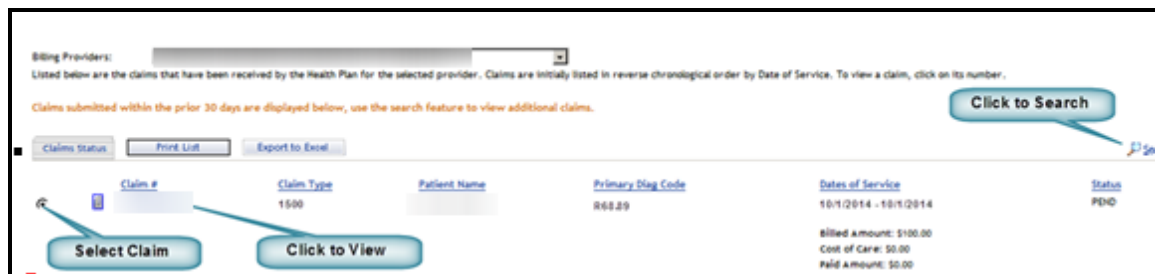


Figure 5-3: Claim Status Screen

3. Claim status identifies the processing stage of the claim. [Table 3](#) below, groups the statuses into three categories: **Initial**, **Awaiting Payment**, and **Finalized**. Claims with an initial status of “Rev” or “Rev Synch” may not be edited. Claims with any other initial status may be edited by the provider. Claims in Finalized status of Paid may be Reversed or Replaced.

**NOTE:** *If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.*

See [Table 3](#) below for more detailed explanations of the claims statuses.

**Table 3: Claim Statuses**

Claim Statuses	
Initial Claim Statuses	
Open	The claim has been entered with the required fields for submission.
Adjudicated	The claim has been processed against the business rules of the system.
Deny	The claim has failed the adjudication process.
Pay	The claim has passed the adjudication process and is ready to be submitted for payment.
Pend	The claim has been set aside for review to determine if it should be paid or denied.
Rev	The claim is an inverse of a previously paid claim that is created to take away any payment error.
Rev Synch	The REV claim is held in this status until the companion replacement claim moves to Pay or Deny.
Awaiting Payment Claim Statuses	
Wait Deny	Awaiting the finalization of the claim denial for inclusion on the remittance advice.
Wait Pay	Awaiting the finalization of the claim payment submitted to AdvantageME for inclusion on the check and remittance advice.
Wait Rev	Awaiting the finalization of the claim reversal for inclusion on the check and remittance advice.
Finalized Claim Statuses	
Paid	The payment process is complete and is included in a Remittance Advice.
Denied	The claim has failed the adjudication process, has been denied and is included in a Remittance Advice.
Reversed	The negative claim has been finalized and is included in a Remittance Advice.

Claim Statuses	
Void	May be created as part of a mass adjustment (reversal and replacement) to void the replacement (adjustment) claim when only a reversal should have occurred. These transactions do not appear on a remittance advice or in an 835. They are administrative transactions only.

4. Users can perform the following actions on selected claims: Edit, Adjudicate, Add Attachments, Reverse, Print Attachment Coversheet, or Print- see [Figure 5-4](#) below.




**Figure 5-4: Claim Submission Standard Buttons**

## 5.1 View a Claim

To view a claim, see [Section 4.3.1: Claim View](#) above.

## 5.2 Search Claim

1. Click the  icon as shown in [Figure 5-3](#) above.
2. Searches may be performed on any of the fields available as shown in [Figure 5-5](#) below.
  - a. The dates entered in the **Date of Service From** and **To** fields must be fewer than 90 days apart.
  - b. The **Search** button finds the claim(s).
  - c. The **Reset** button clears all the values.
  - d. The **Close** button closes the search area.

Date of Service:	<input type="text" value="5/24/2009"/>	To	<input type="text" value="8/22/2009"/>	(MM/DD/YYYY)
Claim #:	<input type="text"/>			
Patient Account Number:	<input type="text"/>	Medical Record Number:	<input type="text"/>	
Patient Last Name:	<input type="text"/>	First Name:	<input type="text"/>	
Date of Birth:	<input type="text"/>			
Social Security Number:	<input type="text"/>			
Member ID:	<input type="text"/>			
Status:	<input type="text" value="ALL"/>			

**Warning: Entering too many search criteria may prevent you from finding the claim**

**Figure 5-5: Claim Search**



### 5.3 Edit Claim

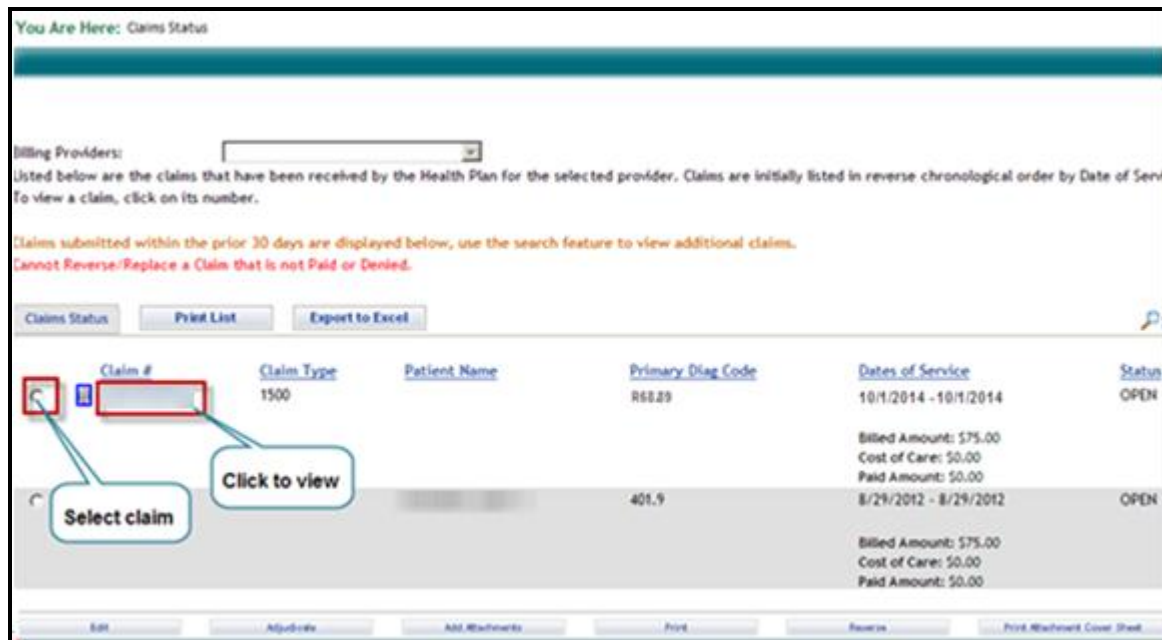
Claims with an initial status of “Rev” or “Rev Synch” **may not be edited**. Claims with any other initial status may be edited. Refer to [Table 3](#) above for the list of initial statuses. Claims with a finalized status of “Reversed” or “Void” cannot be reversed or replaced. “Denied” claims cannot be reversed and should be rebilled.

- Claims listed as "Open", "Adjudicated", "Pay", "Pend", “Rev”, or "Deny" have not been finalized.
- Claims listed as "Paid", “Reversed”, or "Denied" have been finalized (processed through the payment cycle).

Click the option button in front of the claim to select it for editing, as shown in [Figure 5-6](#) below. Click **Edit** to edit the claim.

For additional information about editing a claim see [Section 4.3.3 Edit Claim](#).

**NOTE:** If an attempt is made to Reverse or Replace a claim that is not Finalized, a standard error message will appear: “Cannot Reverse/Replace a Claim that is not Paid or Denied”.



**Figure 5-6: Edit Claim**

Upon completion, three buttons offer further options: **Back**, **Save**, **Adjudicate**, as shown in [Figure 5-7](#) below.

- Click **Back** to return to the screen before.
- Click **Save** to save any changes.
- Click **Adjudicate** to adjudicate the edited claim.



**Figure 5-7: Claim Edits Options**

## 5.4 Adjudicate Claim

To adjudicate a claim, see [Section 4.3.2 Adjudicate Claim](#).

## 5.5 Reversing a Paid Claim

The user may reverse and replace any finalized paid claim. Users may also simply reverse the claim.


- A **Reverse** transaction reverses everything on the claim; the charged amount, payment and the units/visits are negated, etc.
- During the **Replace**, the claim data will be pre-populated. Users will have the option of changing the data prior to resubmission.

**NOTE:** When reopening the COB information, clicking **Cancel** from the COB Information window will delete all primary payment information previously entered. Clicking **Submit** will not delete this information.

**NOTE:** When a reversal claim is submitted, and is in a status of “Rev” or “Rev Synch”, the **Edit** and **Adjudicate** buttons at the bottom of the Claim Status screen will be greyed out.

- The Original Claim, the Reversal Claim and/or the Replacement Claim will be visible in the system. This is for accounting purposes and will show on the next Remittance Advice.

To reverse and replace a claim, follow these steps:

1. Search for a claim by clicking the  icon, as shown in [Figure 5-3](#) above.
2. Select a claim.
3. Select **Reverse** on the claim status page, as shown in [Figure 5-8](#) below.

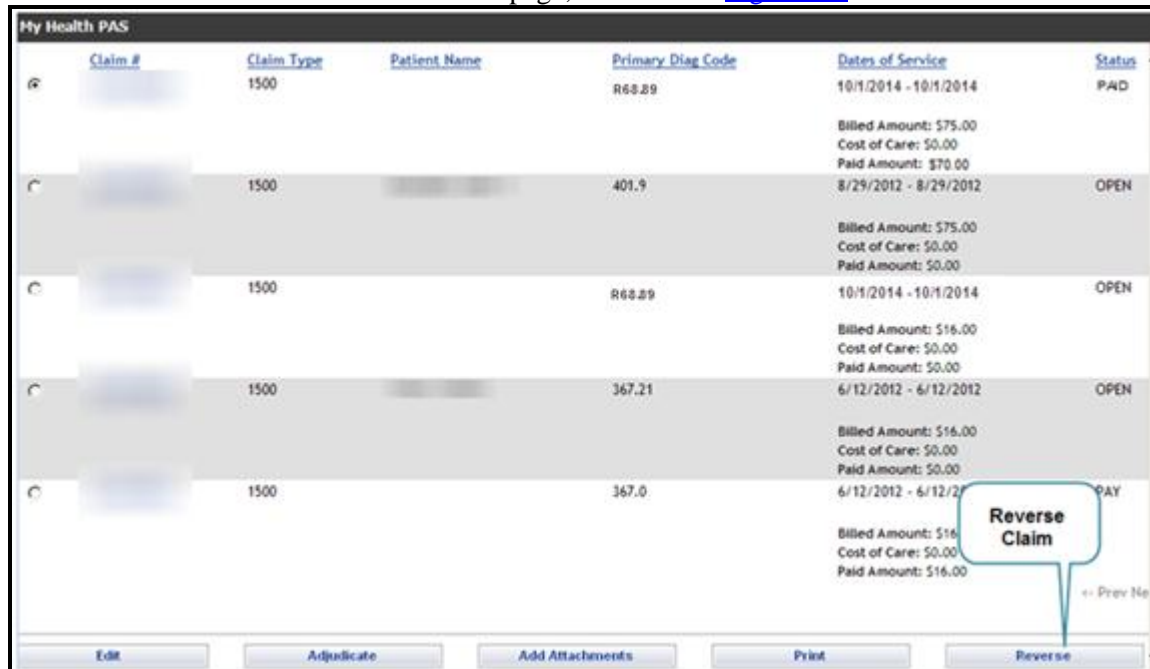


Figure 5-8: Reverse a Claim

4. On the next screen, select the option to **Reverse this claim and create a new claim**.

5. Preserve the existing data by checking the box next to **Use the data from this claim as basis for the new claim**, as shown in [Figure 5-9](#) below. The new claim will have all applicable data copied over.

You Are Here: Claims Status-Reverse Claim

Reverse Claim

Claim Number: [REDACTED]  
Claim Type: UB04  
Member Name: [REDACTED]  
Diagnosis Code: [REDACTED]  
Dates of Service: 3/1/2015 - 3/2/2015

Select the desired option:

☐ Reverse this claim and create a new claim  
☒ Use the data from this claim as the basis for the new claim  
☐ Reverse this claim only

To preserve existing data

Continue Cancel

**Figure 5-9: Claim Status Reverse Claim**

6. Click OK when the verification question pops up, as shown in [Figure 5-10](#) below.

Trading Partner

Provider Home > MHP Viewer

My Health PAS

You Are Here: Claims Status-Reverse Claim

Reverse Claim

Claim Number: [REDACTED]  
Claim Type: 1500  
Member Name: [REDACTED]  
Diagnosis Code: R68.89  
Dates of Service: 10/1/201

Select the desired option:

☐ Reverse this claim and create a new claim  
☒ Use the data from this claim as the basis for t  
☐ Reverse this claim only

Are you sure you want to reverse?

OK Cancel

Continue Cancel

**Figure 5-10: Verification Question**

7. After the revisions are completed, the new claim can be submitted with the updated data.

**NOTE:** When a reversal claim is submitted, and is in a status of “Rev” or “Rev Synch”, the **Edit** and **Adjudicate** buttons at the bottom of the Claim Status screen will be greyed out.

- A **Reversed** Claim will have an R1 (or sequential number) at the end of the Claim number.
  - A **Replaced** Claim will have an A1 (or sequential number) at the end of the Claim number.
    - The Replaced Claim will require a new Patient Account # since it is a new claim.
- [Figure 5-11](#) below, provides an example of a successfully reversed and replaced claim.

The screenshot shows the 'Claim Edit' interface. At the top, a green banner reads 'Trading Partner'. Below it, a breadcrumb trail shows 'Provider Home > MHP Viewer' and 'My Health PAS'. A status bar indicates 'You Are Here: Claim Edit'. A message box states 'Claim is successfully Reversed and Replaced Reversal Claim ID is R1'. The 'Claim Information' section is divided into two columns. The left column contains: Claim Type: 1500, Status: OPEN, Claim #: A1, Log Date: 4/1/2010, Member ID, Member Names, Address, and Dates of Service: 3/22/2010 - 3/22/2010. The right column contains: Billing Provider, Patient Account #, Medical Record #, Prior Auth, Date of Birth, Rendering Provider, Referring Provider (set to NO PROVIDER), and Service Location.

**Figure 5-11: Successfully Reversed and Replace Claim Screen**

Users may also choose **to reverse a claim without creating a replacement claim**, by selecting the **Reverse this Claim Only**- see [Figure 5-12](#) below.

- A Reversal transaction reverses everything on the claim. The charged amount, the payment and the units/visits will be negated, etc.
- A Reversed Claim will have an R1 (or sequential number) at the end of the Claim number.

[Figure 5-12](#) below provides an example of a successfully reversed claim.

**NOTE:** It is not necessary to click on **Continue** once users receive this reversal confirmation screen. Clicking on **Cancel** will bring the user back to the Claim Status page.

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Reverse Claim

Claim Number:

Claim Type: 1500

Member Name:

Diagnosis Code: 882.0

Dates of Service: 4/21/2012 - 4/21/2012

Select the desired option:

☐ Reverse this claim and create a new claim

☐ Use the data from this claim as the basis for the new claim

☒ Reverse this claim only

Reversal ClaimId :

R1

Claim is successfully Reversed

Continue

Cancel

**Figure 5-12: Successfully Reversed Claim Screen**

## Appendix A. Place of Service Code List

**Table 4: Place of Service Code List**

Code	Descriptor
01	Pharmacy
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
17	Walk-in Retail Health Clinic
20	Urgent Care Facility
21	Inpatient Hospital
22 <i><b>NOTE:</b> Should be used when a provider qualifies as a "Provider Based" entity under 42CFR413.65.</i>	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birth Center
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility

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<b>Code</b>	<b>Descriptor</b>
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
54	ICF/MR
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
57	Non-Resident Substance Abuse Treatment Facility
61	Comprehensive Inpatient Rehabilitation Center
62	Comprehensive Outpatient Rehabilitation Center
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Center
81	Independent Laboratory
99	Other

## Appendix B. Transportation Origin/Destination Codes

Single letter modifiers must be combined to indicate the origin and destination for transportation services. These modifiers are entered in the Modifier(s) field of the Claim Service Section. A list of these destination and origin codes is provided in [Table 5](#) below.

**Table 5: Transportation Origin/Destination Codes**

Code	Description
D	Diagnostic or therapeutic site other than P or H
E	Residential domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site transfer (i.e.: airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled Nursing Facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office enroute to the hospital (includes HMP non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called
UC	Unclassified ambulance service



## Appendix C. NDC-J-Code Lookup

The MIHMS Health PAS Online Portal allows providers to query procedure code/NDC combinations and NDC rebate information by specific dates. The online portal will then display valid J-Codes and NDC combinations for MaineCare- see [Figure 5-13](#) below. A list of the parameters required to perform an NDC-J-Code Lookup is provided in [Table 6](#) below.

**DISCLAIMER:** The information used in this lookup is periodically updated; therefore, no guarantee of claim payment is expressed or given.

Provider Home > MHP Viewer

Account Maintenance  
File Exchange  
Form Entry  
Authorization Submission  
Certification Status  
Certification Submission  
Claim Submission  
Claim Status  
Eligibility Verification  
Patient Roster  
Primary Care Roster  
Provider Payment Status  
Referral Submission  
Referral Status  
NDC-J-Code Lookup  
Provider Enrollment Links  
Prior Authorizations  
Training  
Registration in Learning Management System  
Learning Management System  
TP Documents  
Provider Lists  
Frequently Asked Questions  
Provider Directory  
Surveys  
OnLine Website Survey  
Contact Us  
Site Map

Enter Inquiry Date along with NDC and/or J-Code to perform the search. The information on these files is periodically updated, therefore, no guarantee of claim payment is expressed or given.

Inquiry Date: 03/27/2015  
NDC: 00781932785  
J-Code: J1050  
Submit Reset

Select

Disclaimer

NDC Detail

NDC: 00781932785  
Rebateable: YES  
Product Name: CEFTRIAXONE SODIUM  
Generic Name: Ceftriaxone Sodium For Inj 500 MG  
Labeler: NOVAPLUS/SANDOZ

Valid J-Code

J-Code(s) below are valid for this NDC for the date requested. The information on these files is periodically updated, therefore, no guarantee of claim payment is expressed or given.

J-Code	Description
J1050	INJECTION, MEDROXYPROGESTERONE ACETATE, 1 MG

JCode Detail

J-Code: J1050  
HCPCS Description: INJECTION, MEDROXYPROGESTERONE ACETATE, 1 MG

Valid NDC

NDC(s) below are valid for this J-Code for the date requested. The information on these files is periodically updated, therefore, no guarantee of claim payment is expressed or given.

Valid NDC

NDC	Product Name	Labeler	Rebateable
00781932785	CEFTRIAXONE SODIUM	NOVAPLUS/SANDOZ	YES

Figure 5-13: NDC-J-Code Lookup

**Table 6: NDC-J-Code Lookup Parameters**

Field Name	Field Description
<b>Inquiry Date</b>	<p>Enter the Inquiry Date to be used for validation of the information provided.</p> <ul style="list-style-type: none"><li>• <b>Dates must be entered in MM/DD/CCYY format. For example, February 14, 2015 would be entered as “02/14/2015”:</b></li><li>• <b>Cannot be a future date</b></li><li>• <b>Can be selected with the calendar option</b></li><li>• <b>Must be provided for valid combinations to be confirmed</b></li></ul>
<b>NDC</b>	<p><b>Enter a valid 11 digit NDC Code</b></p> <p><b><i>NOTE:</i></b> To see both the Product Name and the generic labeling enter only the NDC code.</p> <p>This tool uses multiple sources of data for validation: Medispan; CMS and Noridian which may cause differences in how the labelers name is displayed. In addition, the name of the NDC labeler could change and result in listing a different name. The intent of this tool is to confirm the validity of the J-code/NDC combination for a specific date.</p>
<b>J-Codes</b>	<p><b>Enter a valid 5 character J-Code</b></p>